Your Health History

Name _____ Date _____

Your age _____ Birthdate _____

Pregnancy History:

If you are pregnant now, what is your due date? _____
Give the date your last pregnancy ended _____

	Circle Yes or No	
Have you ever:		
• had diabetes or high blood pressure while pregnant?	Yes	No
• given birth to a baby early - 1 or more months before due date?	Yes	No
• given birth to a baby weighing less than 5 ½ lbs or more than 9 lbs?	Yes	No
• lost a baby while pregnant, at birth or during the first month of life?	Yes	No
• had a baby with birth defects or medical problems?	Yes	No
Are you now or have you ever been pregnant with twins or triplets?	Yes	No
If you are pregnant now, have you been told that the baby is not growing?	Yes	No
How many months pregnant were you when you first saw a doctor for this pregnancy? _____ months		
How many cigarettes do you smoke a day? _____ day		
How many times a week do you drink beer, wine, or liquor? _____ week		
Have you used cocaine, marijuana, other street drugs or amphetamines or methadone recently?	Yes	No
If you are **pregnant now,** have you lost weight during this pregnancy?	Yes	No
If you are **pregnant now**, what was your weight before pregnancy? _____		
Do you eat large quantities of ice or eat clay, starch or other things that are not food?	Yes	No
Do you have problems with your teeth or gums that cause you not to eat certain foods?	Yes	No
Has a doctor ever told you that you have food allergies?	Yes	No
Has a doctor ever told you that you have any medical conditions or problems?	Yes	No
If you are **breastfeeding now**, is your baby on the WIC program?	Yes	No

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PLEASE STOP HERE - Thank You